August 13, 2007

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Department of Health, Agency of Human Services
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William G. Maddox
Trial Attorney
U.S. Department of Justice
Civil Rights Division
Special Litigation Section
950 Pennsylvania Avenue, NW
Washington, D.C. 20530

Dear Attorneys Beinner and Maddox,

Herein is the second compliance report submitted by Mohammed El-Sabaawi, M.D., and Jeffrey Geller, M.D., M.P.H. pursuant to the Settlement Agreement ("Agreement") entered into between the United States and the State of Vermont (the Agency of Human Services, the Department of Health, the Division of Mental Health and the Vermont State Hospital ("VSH")), this Agreement resolving the investigation by the United States Department of Justice ("DOJ") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. sec 1997.

Our report follows the format of the Agreement with sections of our report numbered and lettered to correspond to the Agreement. Sections generally follow the structure of findings, recommendations, and compliance indication. Recommendations are not explicitly stated when they would derive quite clearly from the findings. Data to substantiate the findings are listed in the Data Section of this report.

The evaluators' recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in the Agreement.

This report represents the concurred opinion of the two experts in this case.

COMPLIANCE DEFINITIONS

Compliance with the Agreement requires that VSH demonstrate substantial compliance for each of the requirements. In this report, the Monitors describe the steps taken by VSH to implement corrective measures and the extent to which VSH has met the requirements of the Agreement. It is noted that each provision in the Agreement has a completion date by which substantial compliance is required. Lack of substantial compliance prior to the completion date does not violate the terms of the Agreement.

This report uses the following terms, which have been agreed upon by the parties:

Sustained Compliance (SusC): Substantial compliance has been maintained in the rated provision for a period of at least one year.

Substantial Compliance (SubC): Substantial compliance with all components of the rated provision. Non-compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance will not constitute failure to maintain substantial compliance.

Significant Compliance (SigC): Considerable compliance has been achieved on the key components of the rated provision, but refinement of work product remains.

Partial Compliance (PC): Compliance has been achieved on most of the key components of the rated provision, but substantial work remains.

Non-Compliance (NC): Non-compliance with most or all of the components of the Agreement provision.

DATA BASE

Documents Reviewed Prior to Visit

- Comprehensive Interdisciplinary Treatment Plan: one per Treatment Team – last one completed.
- Behavioral Treatment Plans: Revisions of four long-standing behavioral interventions with revised datasheets. In-service Training on Behavioral Concepts that Are Useful in Clinical Work.
- Initial Assessments: Guidelines for Recommending a Behavioral Plan, undated. Psychiatric Social Work and Nursing Assessments for all 13 patients admitted in May 2007.
- Policy and Procedure: written or revised since November 2006.
  - Mandatory Reporting Policy, January 17, 2007
  - Volunteer Policy, February 12, 2007
  - Patient Identification Policy, June 4, 2007
  - Advance Directive and Organ and Tissue Donation Policy, May 16, 2007
  - Nursing Assessment Policy, May 25, 2007

  - Patient Death Guidelines, June 4, 2007
  - Procedure for Securing the Scene of an Event, June 7, 2007
  - Emergency Involuntary Procedure Policy, November 16, 2006
  - Treatment Planning Policy, November 16, 2006
- Patient schedule: Current VSH patients' weekly schedules
- Psychosocial treatment: Guide to the Symptom Management Module
- List of all groups currently offered: VSH Weekly Schedule
- Copy of form used by group leaders to communicate observations/findings to Treatment Team: VSH Weekly Program Report
- Psychopharm: list of all patients with current psychiatric medications; description of how polypharmacy is monitored:
  - List of patients with prescribed medications
  - Pharmacist recommendations to the treating psychiatrist
  - Memorandum from Medical Director regarding PRN use
- Diagnosis: list of all patients with Axis I-III diagnoses: First page of each patient's Comprehensive Interdisciplinary Treatment Plan, listing their diagnoses
- Five Annual Psychiatric Assessments done in 2007
- Five Psychology Assessments that include formal testing done in 2007: six VSH Psychology Assessments all completed by Laura Gibson, Ph.D.
- Five Comprehensive Rehabilitation Assessments done in 2007: five Rehabilitation Services Initial Assessments
- List of all patients discharged in 2007 with admission and discharge dates, discharge site, whether readmitted to VSH
- Aftercare plans: Aftercare referral forms for each patient discharged in 2007
- PPV's:
  - List of patients on PPV during May 2007
  - Graph illustrating PPV use
  - Memorandum from Dr. Simpatico addressing PPV's
- Status report on six nursing home patients identified in February 2007 report: Email from Terry Rowe, June 11, 2007
- Status report on each patient currently at VSH who is a chronic medication refuser (greater than one month) and plans to address each patient's medication refusal: Email from Dr. Simpatico, June 13, 2007
- Substance Abuse: list of specific services for SA patients:
  - Email from Terry Rowe, June 12, 2007
  - Nine Substance Abuse Assessments containing services provided, May 23 through June 4, 2007
- Pharmacy:
  - VSH pharmacy protocol, June 11, 2007
  - Five physician's order sheets with recommendations from pharmacist
- Environment: VSH Brooks Additional Safety Graham/Meus-Ockert Work Plan, January 16, 2007
- Safety report 2007: Graham/Meus Architect Report Update, February 5, 2007
- VSH Employee First Report of Injury Forms, January-May 2007

- Minutes of the Safety and Risk Management Committee: February 2007, March 2007, April 2007
- Quality Council, March 28, 2007
- Performance Improvement Plan, February, March, April, May 2007
- List of all patients requiring seclusion/restraints, January 1-May 31, 2007
- Minutes of the Pharmacy and Therapeutics Committee, October 2006 – April 26, 2007
- Patient transfers to local emergency rooms/hospitals in 2007 with dates, names and reason for transfer
- List of all patients, including names, medication regimens (scheduled and PRN) and attending physicians
- VSH Guidelines for Recommending a Behavioral Plan
- Documentation of current behavioral interventions and plans provided to patients at VSH
- VSH current guidelines for medication use
- VSH Clozapine Protocol
- VSH databases regarding patients receiving benzodiazepines and anticholinergic medications
- VSH database regarding patients diagnosed with tardive dyskinesia
- VSH database regarding patients prescribed two or more antipsychotic medications
- VSH aggregated data regarding adverse drug reactions (ADRs) and Medication variance reporting (MVR) since January 1, 2007
- Last 10 completed medication event reporting forms regarding drug variances
- Sample of VSH Peer Review Tools regarding Psychopharmacological Intervention
- VSH current Policy and Procedure regarding Emergency Involuntary Procedures (effective November 11, 2006)
- VSH Special Incident Report (January 1 through May 31, 2007) regarding the administration of involuntary psychotropic medications
- VSH Special Incident Report (January 1 through May 31, 2007) regarding the use of seclusion/restraints
- Records regarding VSH Emergency Involuntary Procedures Reduction Program (EIPRP)
- VSH data, including graphs, regarding mean time per episode of seclusion, hours of seclusion per 1000 patient hours and episodes of seclusion (January 1, 2006 to May 31, 2007)
- VSH data, including graphs, regarding number of patients given involuntary medication and episodes of emergency involuntary medications (January 1, 2006 to May 31, 2007)
- VSH data regarding mean time per episode of restraints, hours of restraints per 1000 patient hours and episodes of restraints (January 1, 2006 to May 31, 2007)

- Participant manual regarding Advanced Non-Abusive Psychological and Physical Intervention (NAPPI) training
- Trainer's manual regarding NAPPI training
- Sample of VSH written final examination regarding NAPPI training
- Nursing staff attendance sheets from Brooks Rehabilitation, Brooks I, Brooks II and Temporary and Miscellaneous staff (NAPPI refresher training)
- VSH Policy regarding Orientation and Conditions of Employment
- VSH Mandatory In-Service Policy (effective June 28, 2007)
- List of patients that experienced seclusion and/or restraints January 1, 2007
- National Association of State Mental Health Program Directors (NASMHPD) Research Institute (NRI) Behavioral Healthcare Performance Measurement System: Summary of National Measurement Calculations
- Database regarding the use of Involuntary Medications, including thresholds of use, since January 1, 2007
- Database regarding the use of seclusion/restraints, including thresholds of use, since January 1, 2007
- Charts of four VSH patients that experienced involuntary administration of medications since January 1, 2007: #28239, #28320, #19881, and #28313
- Charts of four VSH patients that experienced the use of seclusion and/or restraints since January 1, 2007: #28313, #19881, #27157 and #28238
- Charts of all VSH patients who met threshold of Involuntary Administration of Medications since January 1, 2007
- Random sample of charts of VSH patients who met threshold of seclusion and/or restraints since January 1, 2007
- VSH database regarding all incidents reported to Adult Protective Services (APS) since January 1, 2007
- VSH Medical Emergency procedure (effective May 2, 2007)
- Emergency Cart contents form
- Sample sheet of daily check of Emergency Cart Lock Integrity
- Sample Sheet of Safety and Risk Management Committee audit for compliance
- Sample Sheet of attendance at Basic Life Support training and testing
- VSH database regarding patient injuries since January 1, 2007
- Randomly selected sample of Patient Event Reporting Forms
- VSH Governing Body Injuries and Events/Variance Reports (December 2006 to May 2007)

- Staff Injury Reports January 1 to May 31, 2007
- VSH Action Plan for Root Cause Analysis regarding Employee Injuries
- VSH Information Technology (IT) Department update
- VSH Risk Assessment Protocol

Treatment Teams

Richard Monson, M.D.

Robert Duncan, M.D.

Jay Batra, M.D.

Maria Novas-Schmidt, M.D.

John Malloy, M.D.

Individual Meetings with Psychiatrists

Tom Simpatico, M.D., Medical Director
Richard Munson, M.D.
Maria Novas-Schmidt, M.D.
Jay Batra, M.D.
John Malloy, M.D.
Robert Duncan, M.D.

Meetings with Staff

Terry Rowe
Anne Jermane, Nursing Administrator
Tommie Murray, Chief Quality Officer
Diane Bogdan
Elliot Banay, M.A., Staff Psychologist
Margaret Ciechanowicz, Agency of Human Services, Chief Information Officer
Andy Lowe, IT Project Manager
Wendy Magee, Senior IT System's Developer
Scott Perry, R.N., Quality Manager
Sarah Merrill
JoEllen Swaine
Jim Alexander
Patrick Kinner
Mary Beth Bizzari, Pharmacy Director
Laura Gibson, Ph.D., Consultant Psychologist
Denise McCarty, Executive Office Manager

P.G. Singh, M.D., Primary Care Physician (by phone)

Observations

Rehab	6/29:	10:20 a.m., 11:20 a.m., 1:00 p.m.
B-1	6/29:	10:00 a.m., 11:50 a.m., 1:35 p.m.
B-2	6/29:	10:10 a.m., 11:30 a.m., 1:15 p.m.

Behavioral Plans

1	5/30/07
2	5/21/07
3	5/29/07
4	4/31/07
5	4/9/07

Medical Records

#28325	#26807	#28239
#28316	#28122	#28313
#28301	#28204	#19881
#28161	#28227	#28258
#23769	#28320	

Patient	DOB	DOA	DOD	VSH Admit #
#24973				
#25235				
#25411				
#17001				
#28298				
#28083				
#25063				
#28262				
#26897				
#19881				
#28264				
#28306				
#25524				
#23769				
#25917				
#27814				
#28320				
#27151				

Treatment Plans

#27636	6/4/07	#28323	6/8/07
#24752	6/11/07	#25362	6/7/07
#24973	4/26/07	#28310	6/8/07
#24740	6/11/07	#27447	6/7/07
#27063	5/30/07	#17001	6/13/07

Assessments

Psychiatric

#14999	5/21/07	#25220	5/1/07
#28320	5/20/07	#28321	5/27/07
#28318	5/18/07	#27063	5/23/07
#28319	5/18/07	#25411	5/23/07
#28317	5/13/07	#25411	5/14/07
#28316	5/8/07	#27342	5/22/07

Nursing

#14999	5/21/07	#28316	5/8/07
#_ _220	5/1/07	#27063	5/23/07
#25411	5/14/07	#25917	5/31/07
#28317	5/13/07	#28243	2/28/07
#28318	5/18/07	#26549	2/16/07
#28319	5/18/07	#25926	4/27/07
#28321	5/28/07	#28205	3/22/07
#28320	5/20/07		

Social Work

#14999	5/23/07	#25411	5/30/07
#27342	5/23/07	#28316	5/14/07
#28321	5/27/07	#25220	5/7/07
#28320	5/21/07	#28319	5/22/07
#28318	5/22/07	#28317	5/15/07
#25664	5/29/07	#28322	5/30/07
#25411	5/14/07	#27063	5/29/07

Rehab

#25664	5/23/07
#27342	6/8/07
#27843	4/30/07
#27993	4/17/07
#28126	4/17/07

FINDINGS, COMMENTS/RECOMMENDATIONS, AND COMPLIANCE RATINGS

Sec	Settlement Agreement Terms	Compliance	Finding	Comments and Recommendations
IV.	**INTEGRATED TREATMENT PLANNING** By 30 months from the Effective Date hereof, VSH shall provide integrated, individualized protections, services, supports, and treatments (collectively "treatment") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the discipline-specific treatment planning provisions set forth below, VSH shall establish and implement standards, policies, and protocols and/or practices to provide that treatment determinations are consistently coordinated by an interdisciplinary team through integrated treatment planning and embodied in a single, integrated plan.			
A.	Interdisciplinary Teams By 30 months from the Effective Date hereof, each interdisciplinary team's membership shall be dictated by the particular needs, strengths, and preferences of the individual in the team's care, and, at a minimum, the interdisciplinary team for each individual shall:			
1.	Have as its primary objective the provision of individualized, integrated treatment that optimizes the patient's opportunity for recovery and ability to sustain himself/herself in the most appropriate, least restrictive setting, and supports	PC	Following the form rigidly. No matter what comes forth from the patient, the Team does not deviate.	Need to progress to point that Team works with patient in a more naturalistic way doing treatment planning and scribe fills in form. Further training and mentoring.

	the patient's interests of self determination and independence			
2.	be led by a treating psychiatrist who, at a minimum, shall:			
a.	assume primary responsibility for the individual's treatment	SigC	Psychiatrists are now leading Teams. Commendable step. Too often now psychiatrist is doing Treatment planning as a monologue while those others in attendance sit as an audience.	Further training and mentoring.
b.	require that each member of the team participates appropriately in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments	PC	RN Assessments are inadequate because after collecting the data there is no pulling it together into an assessment. SW Assessments are inadequate for the same reason as the RN Assessments. RN Assessments must be completed in considerably less than 24 hours. Policy: Nursing Assessment Policy (E2) states within 24 hours. See also Sec V.	RN Assessment should be within 8 hours. It is unsafe to have patients in a state hospital for up to 24 hours without a nursing assessment. Interventions and recommendations belong in each discipline's assessments or in none, not in some but not others. Since a CTP is being done at or close to admission, Assessments do not need intervention plans except psych.
c.	require that the treatment team functions in an interdisciplinary fashion	SigC	Based on observations of all treatment teams, significant progress is noted. There is considerable variation in meeting this parameter across teams.	Further training and mentoring.
d.	require that the scheduling and coordination of assessments and team meetings, the drafting of	SigC	Major improvement with scribe function in getting treatment plans into patients' medical records in a timely	Develop a schedule which eliminates (or at least minimizes overlap between treatment team meeting and PSR

	integrated treatment plans, and the scheduling and coordination of necessary progress reviews occur in a timely fashion		fashion.	groups, i.e., "Mall hours."
3.	have its composition dictated by the individual's particular needs, strengths, and preferences, but shall consist of a stable core of members, including the individual, the treating psychiatrist, the nurse, and the social worker and, as the core team determines is clinically appropriate, other team members, who may include the individual's family, guardian, advocates, and the pharmacist and other clinical staff	SubC	Generally met. RT generally absent	See recommendation at A.2.d.
4.	complete training on the development and implementation of interdisciplinary treatment plans to the point that integrated treatment plans meet the requirements of section IV.B., infra; and	PC	Based on a review of ten (10) Comprehensive Interdisciplinary Treatment Plans (see data section), there is evidence of significant improvement. However, Treatment Plans consistently lack features called for in the Treatment Planning Policy (B32) as italicized: 1. Treatment plans shall provide: a) where possible, individuals have *substantive, identifiable* input into their treatment plans; c) individuals are *informed of the purposes and side effects of medication*; d) the therapeutic means by which the treatment goals for the particular individual shall be addressed, monitored, *reported, and documented* are specifically identified in each treatment plan; e) treatment and *medication* regiments are modified, as appropriate, considering factors such	Further training and mentoring.

			as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs. 2. Treatment planning shall be based on a comprehensive case formulation for each individual that emanates from an integration of the *discipline-specific assessments* of the individual. 3. The treatment team shall c) *write the objectives in behavioral and measurable terms*; d) provide that there are interventions that relate to each objective, specifying who will do what, *within what timeframe*, to assist the individual to meet his/her goals as specified in the objective; e) design a program of interventions throughout the individual's day with a *minimum of 20 hours* of clinically appropriate treatment/rehabilitation per week; and f) provide that each treatment plan *integrates and coordinates all selected services*, supports, and treatments provided by or through VSH for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals. 4. Treatment planning shall be *outcome-driven*.	
5.	meet every 30 days, and more frequently as clinically indicated	SubC		
B.	Integrated Treatment Plans By 24 months from the Effective Date hereof,	SubC	VSH Policy B32: Treatment Planning Policy	

	VSH shall develop and implement policies and/or protocols regarding the development of treatment plans consistent with generally accepted professional standards of care, to provide that:			
1.	where possible, individuals have substantive, identifiable input into their treatment plans	NC	As witnessed in all five (5) Treatment Teams attended, patients either refused to attend or leave after period of short attendance.	See Sec A.1.
2.	treatment planning provides timely attention to the needs of each individual, in particular:			
a.	initial treatment plans are completed within 24 hours of admission	PC	Review of medical records (see data section) reveals these are not up to standard, although there are some directives for initial treatment within 24 hours.	Further training and mentoring.
b.	master treatment plans are completed within seven days of admission	SubC		
c.	treatment plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter	SubC		
3.	individuals are informed of the purposes and side effects of medication	NC	No evidence this occurs as part of Treatment Planning meeting or as a directive of Treatment Plan.	Further training and mentoring.
4.	each treatment plan specifically identifies the therapeutic means by which the treatment goals for the particular individual shall be addressed, monitored, reported, and documented, consistent with generally accepted professional standards of care	SigC	Significant improvement based on review of 10 Treatment Plans.	Further training and mentoring.

5.	treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs	SigC	A review of Ten (10) Treatment Plans and 26 medical records indicates this is much improved but remains inconsistent.	Mentoring. QA audits.
C.	By 30 months from the Effective Date hereof, VSH shall use these policies and/or protocols to provide that treatment planning is based on a comprehensive case formulation for each individual that emanates from an integration of the discipline-specific assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	SubC	Major improvement. Formulations consistently present in psychiatric assessment.	
1.	be derived from analyses of the information gathered from discipline-specific assessments, including diagnosis and differential diagnosis	PC	Present in psychiatric assessment, not present in nursing, social work, or rehabilitation assessment.	Mentoring and Training.
2.	include a review of pertinent history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history	PC	Present in psychiatric assessment, not present in nursing, social work, or rehabilitation assessment.	
3.	consider biochemical and psychosocial factors for each category in Section IV.C.2., supra	PC	Present in psychiatric assessment, not present in nursing, social work, or rehabilitation assessment.	
4.	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions	NC	All disciplines need improvement on this variable.	

5.	enable the treatment team to reach sound determinations about each individual's treatment and habilitation needs	PC	Major improvement.	Move focus from simply the patient, to the patient and the person.
6.	make preliminary determinations as to the least restrictive setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge	PC	Discharge from VSH to another inpatient psychiatric unit with zero to poor clinical rationale: # The data provided showed no discharges to other hospitals from March→July. The 3 records cited are before March 2007. The two MRNs represent one patient. The clinical rationale for return to VSH was related to patient deterioration and safety issues (firesetting). A crisis plan for Second Spring should be developed by Second Spring and VSH prior to discharge. Returned patients from Second Spring Why an emergency: Why no written crisis plan:	Reevaluate this practice.
D.	By 30 months from the Effective Date hereof, VSH shall use these policies and/or protocols to provide that treatment planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), and that it provides an opportunity to improve each individual's health and well being, consistent with generally accepted professional standards of care. Specifically, the treatment team shall:			
1.	develop and prioritize reasonable and attainable goals/objectives (i.e., relevant to each individual's level of functioning) that build on the individual's	SubC	Excellent progress. Refinement necessary. Based on review of 10 Treatment Plans.	Further Training and Mentoring.

	strengths and address the individual's identified needs and, if any identified needs are not to be addressed, provide a rationale for not addressing the need			
2.	provide that the goals/objectives address treatment (e.g., for a disease or disorder) and rehabilitation (e.g., skills/supports/quality of life activities)	SubC	Excellent progress. Refinement necessary. Base on review of 10 Treatment Plans.	Further Training and Mentoring.
3.	write the objectives in behavioral and measurable terms	PC	Based on review of 10 Treatment Plans, Treatment Teams are better at this, but still continue to struggle. A majority of goals do not yet meet these criteria.	Further Training and Mentoring.
4.	provide that there are interventions that relate to each objective, specifying who will do what and within what time frame, to assist the individual to meet his/her goals as specified in the objective	PC	Based on review of 10 Treatment Plans, Treatment Teams are better at this, but still continue to struggle. A majority of goals do not yet meet these criteria.	Further Training and Mentoring.
5.	design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation per week	NC	Not yet achieved. A menu of groups was provided, but these fail to meet the standard of clinically appropriate treatment for each patient.	Develop off unit PSR program with 20 hours of individualized treatment per week.
6.	provide that each treatment plan integrates and coordinates all selected services, supports, and treatments provided by or through VSH for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals	NC	Not yet even approximately achieved.	Develop off unit PSR program with 20 hours of individualized treatment per week.

E.	By 30 months from the Effective Date hereof, VSH shall revise treatment plans, as appropriate, to provide that planning is outcome driven and based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified treatment objectives, consistent with generally accepted professional standards of care. Specifically, the treatment team shall:			
1.	revise the objectives, as appropriate, to reflect the individual's changing needs	SubC		
2.	monitor, at least monthly, the goals, objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes	SubC		
3.	review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors	PC	This has started, but at this point is not yet consistently done for mandated thresholds, much less other specific training for psychiatrists and social workers on recidivism	Further Training and Mentoring.
4.	provide that the review process includes an assessment of progress related to discharge	PC	Nascent efforts in evidence. Recidivism never considered as a problem on CITP.	Specific training for psychiatrists and social workers on recidivism.
5.	base progress reviews and revision recommendations on data collected as specified in the treatment plan	NC	Group notes unhelpful, often useless. Section "describe goal relevant behavior" rarely completed, and if it is, it is rarely done correctly. almost all; see specifically # Data collected for Behavioral Plans of questionable validity. See data section for BP's reviewed.	Further Training and Mentoring.

V.	**MENTAL HEALTH ASSESSMENTS** By 24 months from the Effective Date hereof, VSH shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to VSH, an assessment of the conditions responsible for the individual's admission, and provide that it is accurate and complete to the degree possible given the obtainable information at the time of admission. To the degree possible given the obtainable information, the individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the patient's condition, and, when necessary, for revising assessments and treatment plans in accordance with new information that comes to light. Thereafter, each individual shall receive a reassessment whenever there has been a significant change in the individual's status, a lack of expected improvement resulting from treatment clinically indicated, or six months since the previous reassessment.			
A.	Psychiatric Assessments and Diagnoses			
1.	By 24 months from the Effective Date hereof, VSH shall use the diagnostic protocols in the most current Diagnostics and Statistics Manual ("DSM") for reaching the most accurate psychiatric diagnoses.	SubC		

2.	By 24 months from the Effective Date hereof, VSH shall ensure that all psychiatric assessments are consistent with VSH's standard diagnostic protocols.	SubC	Generally met, but see (diagnosis different on CITP and psychiatric progress note of same date).	
3.	By 24 months from the Effective Date hereof, VSH shall ensure that, within 24 hours of an individual's admission to VSH, the individual receives an initial psychiatric assessment, consistent with VSH's protocols.	SubC		
4.	By 24 months from the Effective Date hereof, VSH shall ensure that:			
a.	clinically justifiable, current assessments and diagnoses are provided for each individual	SubC		
b.	the documented justification of the diagnoses are in accord with the criteria contained in the most current DSM	SubC		
c.	differential diagnoses, "rule out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed, through clinically appropriate assessments, and resolved in a clinically justifiable manner	SubC	Excellent progress.	
d.	each individual's psychiatric assessments, diagnoses, and medications are clinically justified consistent with generally accepted professional standards of care	PC	Absence of review of medications on admission with updated MD rationale. # (three antipsychotics)	
5.	By 18 months from the Effective Date hereof, VSH shall develop protocols consistent with	SubC	Met through CITP review schedule	

	generally accepted professional standards of care to ensure an ongoing and timely reassessment of the psychiatric causes of the individual's continued hospitalization.		and Annual Psychiatric Assessments.	
B.	Psychological Assessments			
1.	By 30 months from the Effective Date hereof, VSH shall ensure that patients referred by the treating psychiatrist for psychological assessment receive that assessment, consistent with generally accepted professional standards of care, in a timely manner. These assessments may include diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), rehabilitation and habilitation interventions, behavioral assessments (including functional analysis of behavior in all settings), and personality assessments.	PC	Exception is work by Laura Gibson, Ph.D. who is providing psychological assessments of VSH patients. See also sec VIIB.	See sec VIIB.
2.	By 30 months from the Effective Date hereof, all psychological assessments, consistent with generally accepted professional standards of care, shall:	NC	Same as sec 1 above.	Same as 1 above.
a.	expressly state the purpose(s) for which they are performed			
b.	be based on current, accurate, and complete data			

c.	include an accurate, complete, and up to date summary of the individual's relevant, clinical, and functional history and response to previous treatment			
d.	where relevant to the consultation, include sufficient elements of behavioral assessments to determine whether behavioral supports or interventions are warranted or whether a comprehensive applied behavioral analysis and plan are required			
e.	include determinations specifically addressing the purpose(s) of the assessment	NC		
f.	include a summary of the empirical basis for all conclusions, where possible			
g.	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records, or re evaluations that should be undertaken in endeavoring to resolve such issues			
3.	By 30 months from the Effective Date hereof, previously completed psychological assessments of individuals currently at VSH shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in Section V.B., supra. By 30 months from the Effective Date hereof, appropriate psychological assessments shall be provided in a timely manner, whenever clinically determined by the team, consistent with generally	NC	Same as sec 1 above.	Same as sec 1 above.

	accepted professional standards of care. These may include whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment or therapeutic programming. The assessment may also be used where clinical information is otherwise insufficient and to address unresolved clinical or diagnostic questions, including "rule out" and deferred diagnoses.			
4.	By 30 months from the Effective Date hereof, when an assessment is completed, VSH shall ensure that treating psychologists communicate and interpret psychological assessment results to the treatment teams, along with the implications of those results for diagnosis and treatment.	NC	Same as sec 1 above.	Same as sec 1 above.
C.	Rehabilitation Assessments			
1.	The treating psychiatrist shall determine and document his or her decision, prior to the initial treatment team meeting, whether a comprehensive rehabilitation assessment is required for a patient. When requested by the treating psychiatrist, or otherwise requested by the treatment team or member of the treatment team, VSH shall perform a comprehensive rehabilitation assessment, consistent with generally accepted professional standards of care and the requirements of this Agreement. Any decision not to require a rehabilitation assessment shall be documented in the patient's record and	NC	No Comprehensive Rehabilitation Assessments were found.	Needs to be on the agenda of the new Director of Activities.

	contain a brief description of the reason(s) for the decision.			
2.	By 30 months from the Effective Date hereof, all rehabilitation assessments will be consistent with generally accepted professional standards of care and shall:	NC	Below standard – No Rehabilitation formulation	See C.1.
a.	be accurate and coherent as to the individual's functional abilities		– No relationship between data, goals, summary and recommendations.	
b.	identify the individual's life skills prior to, and over the course of, the mental illness or disorder		– Initial Assessment is actually a screening.	
c.	identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses		– Screening does not lead to Comprehensive Assessment in appropriate cases (or any cases for that matter).	
d.	provide specific strategies to engage the individual in appropriate activities that he or she views as personally meaningful and productive			
3.	By 30 months from the Effective Date hereof, rehabilitation assessments of all individuals currently residing at VSH who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in Section V.C.2., supra.	NC	See C.1.	See C.1.
D.	Social History Assessments By 18 months from the Effective Date hereof, VSH shall ensure that each individual has a social history evaluation that is consistent with	PC	Social History Assessments gather data well, but fail to integrate the data into a social assessment that informs the Treatment Team of relevant social	Social Work continuing education intervention.

	generally accepted professional standards of care. This includes identifying factual inconsistencies among sources, resolving or attempting to resolve inconsistencies, explaining the rationale for the resolution offered, and reliably informing the individual's treatment team about the individual's relevant social factors.		factors.	
VI.	**DISCHARGE PLANNING AND COMMUNITY INTEGRATION** Taking into account the limitations of court imposed confinement, VSH shall pursue actively the appropriate discharge of individuals to the most integrated, appropriate setting that is consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.	NC	VSH's ability to do this is, in part, interfered with by VSH admitting patients that are questionable as follows: Question of legitimacy of transfer from inpatient general hospital psychiatric unit: #s MR cases Admission without documentation of mental illness, or behavior appears to be related to MR: #s Readmission without foundation: #	Requires review at levels above VSH.
A.	By 30 months from the Effective Date hereof, VSH shall identify at admission and address in treatment planning the particular considerations for each individual bearing on discharge, including:			
1.	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal goals	SubC		
2.	the individual's symptoms of mental illness or psychiatric distress	SubC		

3.	barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previously unsuccessful placements, to the extent that they are known	SigC	Failure to address recidivism, see Sec IV.E.4.	
4.	the skills necessary to live in a setting in which the individual may be placed	NC	Absence of adequate PSR programming – see Sec VII means these skills are not being addressed.	
B.	By six months from the Effective Date hereof, VSH shall provide the opportunity, beginning at the time of admission and continuously throughout the individual's stay, for the individual to be an active participant in the discharge planning process, as appropriate.	NC	Not consistently occurring – see Sec IV.B.1.	
C.	By 30 months from the Effective Date hereof, VSH shall ensure that, consistent with generally accepted professional standards of care, each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:	PC	Occurs when discharge is identified as a problem, but is not yet a specific part of CITP.	Modification of CITP.
1.	measurable interventions regarding his or her particular discharge considerations			
2.	the persons responsible for accomplishing the interventions			
3.	the time frames for completion of the interventions			
D.	By 24 months from the Effective Date hereof, when clinically indicated, VSH shall transition	SigC	Discharge from VSH to another inpatient psychiatric unit with zero to poor clinical rationale:	

	individuals into the community consistent with generally accepted professional standards of care. In particular, VSH shall ensure that individuals receive adequate assistance in transitioning prior to discharge.		# Returned patients from Second Spring Why an emergency: # Why no written crisis plan: # Dr. Simpatico has instructed the VSH psychiatrists to clear all intended PPVs with him prior to implementation. This will allow him to see that VSH is using PPVs in a way that facilitates the reintegration of VSH patients into the community while keeping the time on PPV to an acceptable minimum. He is not likely to approve PPVs when one of VSH patients is to be moved to one of the DH inpatient psychiatric units. Dr. Simpatico indicates it is hard to justify why a patient would be simultaneously open at two psychiatric hospitals. In May 2007, there were 8 patients on PPV's. The PPV's ranged in length from 11 days to 29 days. Two PPV's resulted in readmission to VSH. Three PPV's resulted in successful discharge to Second Spring. No PPV resulted in a successful discharge to another psychiatric hospital – in fact, there have been no PPV's to another hospital since January 2007. The outcomes for the 6 Nursing Home patients identified in the February 2007 report are as follows: 1. was placed in a community residence on Pre-Placement Visit on 2-8-07. He was discharged on 3-8-07 and is doing well.	

			2. was placed in a community residence on Pre-Placement Visit on 2-6-07. He was discharged on 3-5-07 and is doing well. 3 was placed in a community residence on Pre-Placement Visit on 2-8-07. He was discharged on 3-8-07 and is doing well. 4 was placed in a community care home on Pre-Placement Visit on 1-30-07. He was discharged on 2-13-07 and is doing well. 5 is an inpatient at VSH. Her treatment team is working with Northwest Counseling Service and her guardian to develop a discharge plan. 6 is an inpatient at VSH. Her treatment team is working with Northwest Counseling Service and her guardian to develop a discharge plan	
E.	Discharge planning shall not be concluded without the referral of a resident to an appropriate set of supports and services, the conveyance of information necessary for discharge, the acceptance of the resident for the services, and the discharge of the resident.	NC	Discharge from VSH to another inpatient psychiatric unit with zero to poor clinical rationale: # Returned patients from Second Spring. Why an emergency: # Why no written crisis plan: # Of 111 discharges to non-DOC sites, January 1-June 9, 2007, 17 (19%) went to locations not considered permanent, or even intermediate LOS sites:	

			Psychiatric hospital 8 Medical hospital 1 Motel 4 Homeless/Shelter 6 Crisis bed 2	
F.	By 30 months from the Effective Date hereof, the State shall develop and implement a quality assurance/improvement system to monitor the discharge process.	NC	Of the 117 discharges, January 1, 2007-June 9, 2007, 60 were readmission to VSH. Of the 60 readmissions, there were 15 discharges and readmissions within this time period. This is a six-month recidivism rate of 13% (15/117). Of the 117 discharges, January 1, 2007-June 9, 2007, there were 102 persons discharged. One person had 8 discharges. Twenty-two persons (22%) were discharged to unknown locations. Discharges to jail do not account for recidivism. Of the 6 persons discharged to corrections, none are a repeat admission after this discharge within the period of these data.	VSH appears to have the capacity to do this, but needs to turn its attention to this task.
VII.	**SPECIFIC TREATMENT SERVICES**			
A.	Psychiatric Care By 30 months from the Effective Date hereof, VSH shall provide all of the individuals it serves with adequate and appropriate routine and emergency psychiatric and mental health services consistent with generally accepted professional standards of care.	SubC	No patient has been referred fro ECT in the memory of any active VSH staff.	
1.	By 30 months from the Effective Date hereof, VSH shall develop and implement policies and/or			

	protocols regarding the provision of psychiatric care consistent with generally accepted professional standards of care. In particular, policies and/or protocols shall address physician practices regarding:			
a.	documentation of psychiatric assessments and ongoing reassessments as per Section V.A., supra	SubC	The admission psychiatric assessments are, in general, completed in a timely manner (within 24 hours of admission). The facility has yet to address the deficiency regarding the initial psychiatric plans of care. The admission psychiatric assessments still fail to include a plan of care to ensure the safety of patients, direct pharmacologic and other treatment interventions and special precautions and provide needed diagnostic testing during early hospitalization. This deficiency was noted in all the charts reviewed. Many admission psychiatric assessments include deficiencies in the completeness of mental status examinations (e.g. cognitive testing and assessment of insight and judgment) and fail to integrate information from collateral sources and other disciplines. VSH has yet to implement a requirement for a follow-up date by the seventh hospital day that can correct these deficiencies.	Needs to be formalized in P/P. Ensure documentation of an initial psychiatric plan to correct the deficiency identified above. Ensure completeness of the admission psychiatric assessments and documentation of an update of these assessments by the seventh hospital day to correct the deficiencies outlined above. Develop and implement tracking and monitoring systems to assess compliance on an ongoing basis.
b.	documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow up	SubC	The psychiatric reassessments, as documented in progress notes are, in general, still focused on a cross-sectional evaluation of the individual	Needs to be formalized in P/P. Implement the newly developed templates of psychiatric progress

			at the time of the interaction and rarely provide meaningful review of important developments in the individual's condition, and their context, during the previous interval. In too many charts, there is failure to provide timely and adequate modifications of the scheduled medication regimen even in response to adverse developments in the individual's condition, including behaviors that require the use of restrictive interventions. To address these deficiencies VSH developed a template for a "Basic Physician Progress Note." This form is designed to ensure review and assessment by the attending and on-call physicians of the emergency use of restrictive interventions and the use of PRN medications during the previous 24 hours. This form does not address the use of Stat medications. In addition, the facility standardized the current format of progress note documentation to include a requirement for completion of the interval history and an expectation of review of restrictive interventions and of modification of treatment based on this review. The facility has yet to implement the newly developed templates, to formalize the requirements in its current procedures and to institute monitoring process to ensure proper	notes. Ensure that the template for the "Basic Physician Progress Note" also addresses the use of STAT medications during the previous 24 hours interval. Formalize expectations regarding the proper completion of the new progress note templates in the facility's policies/procedures/orientation manuals. Ensure documentation of integrated pharmacological and behavioral interventions in the charts of patients receiving both modalities. In these charts, the psychiatric reassessments, as documented in progress notes, should include evidence of: a) Physician's review of the behavioral modalities prior to their implementation to ensure compatibility with psychiatric formulation. b) An exchange of data between the psychiatrist and the psychologist in order to distinguish learned behaviors from those that are targeted for pharmacological therapies. c) Attempts to update the diagnosis and modify medication management based on a) and b) above. Develop and implement a mechanism to identify patients who are appropriate candidates for ECT and ensure that these patients receive

			implementation. The charts of patients who are currently receiving behavioral plans and other interventions still fail to include documentation of integrated pharmacological and behavioral treatment modalities. There is failure to assess and refer residents who are refractory to current drug regimens for electroconvulsive treatment (ECT) when clinically indicated. The Medical Director stated that patients who are deemed appropriate for ECT prior to admission are diverted to other Facilities where ECT is provided on-site. The Medical Director also acknowledged that ECT is probably under-utilized at VSH for those patients who are drug refractory during their hospital stay and that a mechanism should be developed to identify these individuals and to refer them for needed treatment.	needed treatment. Develop and implement tracking and monitoring system to assess compliance on an ongoing basis.
c.	timely and justifiable updates of diagnosis and treatment, as clinically appropriate	SubC	Reviews of charts and other documents indicated that VSH has made progress in the finalization of diagnoses listed as NOS in a timely manner. According to the facility's database, during the past six months, twenty one patients were admitted with diagnoses listed as NOS and no patient was discharged with these diagnoses.	Needs to be formalized in P/P. Same as in VII.A.b. Ensure that psychiatric progress notes document timely and appropriate work-ups and consultations, as needed, to update the psychiatric diagnosis.
d.	documentation of analyses of risks and benefits	NC	Fails to be consistently done for	

	of chosen treatment interventions		psychopharm treatment, essentially absent for all other treatments.	
e.	assessment of, and attention to, high risk behaviors (e.g., assaults, self harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks	NC	Very high rate of utilization of 1:1 staffing. In general, the psychiatric reassessments, as documented in progress notes, still fail to track a variety of psychiatric risk factors, assess contributing factors and provide timely supports and interventions to minimize the risk. The facility has yet to implement a mechanism to track and monitor this requirement.	Needs to be formalized in P/P. Same as in VII.A.b. Ensure that progress note documentation corrects the deficiency identified above.
f.	documentation of, and responses to, side effects of prescribed medications	SigC	Psychiatric Progress Note – work off template duplicative # not always accurate #	
g.	timely review of the use of "pro re nata" or "as needed" ("PRN") medications and adjustment of regular treatment, as indicated, based on such use	NC	Modification of PRN order practice: As of May 14, PRN meds will be ordered with an automatic stop date of 7 days. Orders will discontinue on the 7th day at noon. On or before the 7th day, the physician will evaluate and decide whether or not to reorder PRN for additional 7 day period. PRNs will be discontinued at any time they are deemed unnecessary as per usual practice. Daily reports will be sent to the units to inform physicians and nurses of the PRNs that will cease on the following day. This will give the physician and nurse an opportunity to follow-up on these orders. An exception to the automatic stop will be PRNs ordered by an on-call physician. When an on-call physician orders PRNs, the orders will be good until noon of the next business day. This	Evaluate effects of new directive.

			will allow treating physicians to evaluate the on-call physician's orders and re-order if deemed necessary. Chart reviews demonstrated that VSH has yet to correct the following deficiencies regarding the use of PRN/Stat medications: a) The prescription and administration of PRN medications are generally based on generic and ill-defined indications (typically for "agitation.") Such practice lends itself to misuse of these modalities and increases the risk of use for the convenience of staff and as a substitute for active treatment. b) There is almost universal failure by the attending physicians to review the use of medications prescribed on an as needed basis (PRN) and/or Stat and to utilize the use of these medications to refine diagnosis and/or adjust regular treatment. To address these deficiencies, the Medical Director recently issued a memorandum regarding automatic stop orders on PRN medications by the end of seven calendar days of use.	Same as in VII.A.c. Implement newly developed procedure regarding automatic stop dates of PRN medication use by the seventh day. After two months of implementation, the procedure should require reordering of PRN medications every 72 hours of use.
2.	By 30 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols to ensure system wide monitoring of the safety, effectiveness, and appropriateness of		Psychopharmacology Data No. patients on any psychotropic: 50 No. patients on two	Justification/rationale for medications as documented in the medical record needs to be strengthened as described in specific sections below.

	all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and/or protocols shall address:		antipsychotics: 12 (24%) No. patients on a benzodiazepine: 9 (18%)	
a.	monitoring of the use of psychotropic medications to ensure that they are:	PC	VSH has maintained a Pharmacy and Therapeutics Committee that provides some oversight regarding medication management. The facility revised the membership of the committee to include a dietary representative. VSH recently developed drafts of medication guidelines that address the clinical and laboratory monitoring of a variety of psychiatric medications. These guidelines are intended to serve as the basis for a Drug Utilization Evaluation (DUE) system (see VII.A.d below). Reviews of charts and the facility's databases showed that VSH has made progress in the use of psychotropic medications for patients at risk. The following are examples: a) As mentioned earlier, the facility has developed a procedure to ensure automatic stop date after seven calendar days of PRN medication orders. b) The facility has decreased the practice of prescribing long-term benzodiazepine treatment for patients currently diagnosed with substance use disorders and/or cognitive disorders. The database shows that at this time, no patient at VSH receives regular benzodiazepines treatment for	Develop and implement a food-drug interactions procedure utilizing the dietary representative to the P&T Committee. Develop procedures that establish facility's standards regarding high-risk medication uses including PRN/Stat medications, long-term use of benzodiazepines, anticholinergic medications and antipsychotic polypharmacy and monitoring and management of residents suffering from TD. These standards must be aligned with current literature, professional practice guidelines and relevant clinical experience. Ensure proper documentation of the benefits and risks of benzodiazepine use for patients who have documented history of substance use disorders. Develop and implement monitoring/peer review systems to ensure compliance with facility standards. Identify practitioner trends/patterns, integrate data in the current peer review system and institute educational corrective actions, as needed.

			more than two months in the presence of a current diagnosis of substance use disorder and/or cognitive disorder. Only one patient (#) currently receives lorazepam PRN in presence of a diagnosis of substance use disorder and/or cognitive disorder. However, chart reviews show that several patients have documented history of substance use disorders and are receiving long-term treatment with benzodiazepines without documentation of an assessment of the benefits and risks of this practice. c) The facility has decreased the regular use of anticholinergic medications on a long-term basis for more than two months for patients diagnosed with cognitive disorders. The database shows that, at this time, one patient (#) receives regular long-term treatment with benztropine in presence of a diagnosis of mental retardation. d) Only one patient (#) currently receives treatment with benztropine PRN in presence of a diagnosis of tardive dyskinesia. e) None of the patients currently identified by the facility to have a diagnosis of TD receives treatment with conventional antipsychotic agent.	
i.	clinically justified	PC	Standing orders for benzodiazepines without rationale #s, , (exception #)	See sec 2 above.

			Absence of treatment for paraphilias # Polypharmacy through use of multiple different STAT medications: #	
ii.	prescribed in therapeutic amounts, as dictated by the needs of the individual patient		In the event of a physician wishing to exceed the established VSH maximum dose for a medication, the prescribing physician must first communicate this wish to the pharmacist; enter a note in the medical record explaining the clinical need to exceed the VSH maximum dose threshold; and obtain a second opinion from a colleague regarding the clinical need to exceed the VSH maximum dose threshold (the colleague must also write a note in the medical record explaining the clinical need to exceed the VSH maximum dose threshold; a copy of this second opinion note is sent to the pharmacist). In the event of a physician wishing to prescribe two or more neuroleptics contemporaneously, the physician must communicate this wish to the pharmacist; enter a note in the medical record explaining the clinical need to prescribe two or more neuroleptics contemporaneously. (If the purpose is to effect a cross-taper from one to another single neuroleptic, this should be clearly noted.) If there is intent to maintain the patient on two or more neuroleptics contemporaneously, there needs to be a note in the medical record explaining the clinical need to do this with a second opinion from a colleague regarding the clinical need to do this. The colleague must also write a note in the medical record	See sec 2 above.
iii.	tailored to each individual's clinical needs			

			explaining the clinical need to prescribe two or more neuroleptics contemporaneously. Copies of the second opinion note are sent to the pharmacist. Over max dose without review or second opinion # (current).	
iv.	monitored for effectiveness against the objectives of the individual's treatment plan	PC	Absence of second opinion for psychopharmacologic practices as required by VSH: #; # (verbal statement by Attending is not enough)	Enforce policy and procedure.
v.	monitored appropriately for side effects	PC	Inadequate Medical No lab tests because "patient has not allowed them" [for 8 months!]: #H&PE never done #No written documentation from general hospital when patient sent for medical evaluation #	See sec 2 above. Physician cannot abdicate prescribing authority to the patient.
vi.	properly documented			
b.	monitoring of the use of PRN medications to ensure that these medications are clinically justified and administered on a time limited basis	PC	PRN benzodiazepine's without adequate explanation: #s and PRN's Multiple different PRN's given to patient at her request, including antipsychotic #	See secs 2a and 2.a.v. above.
c.	timely identification, reporting, data analyses, and follow up remedial action regarding adverse drug reactions reporting ("ADR")	PC	VSH has revised the definition of ADRs. The new definition comports with current generally accepted standards. VSH has yet to revise its data collection tool to improve information gathering regarding ADRs. Since January 1, 2007, 10 ADRs have	Revise the current data collection tool and system for reporting, investigating and analyzing ADRs to address and correct the deficiencies.

			been reported to the P&T Committee using the current data collection tool (Medication Event reporting Form). During the previous six months (July 1 to December 31, 2006), three ADRs had been reported. While this represents some increase in reporting, there continues to be serious under-reporting given the number of patients receiving complex and high dose medication regimens at the facility. The current system of ADR reporting demonstrates the same deficiencies mentioned in the previous report of October 2006. The following is an outline: a) There is serious under-reporting of ADRs at VSH. b) VSH fails to provide adequate instruction to its clinical staff regarding the proper reporting and investigation and analysis of ADRs. Specifically, the facility does not provide information or have written guidelines regarding the requirements for: i. Classification of reporting discipline. ii. Proper description of details of the reaction. iii. Additional circumstances surrounding the reaction, including how reaction was discovered, relevant history, allergies, etc. iv. Review of all medications that the individual was actually receiving at the time of the ADR.	

			v. Information about all medications that are suspected or could be suspected of causing the reaction. vi. A rating of severity/outcome of the ADR. vii. A probability rating, including if more than one drug is suspected of causing the ADR. viii. Information about type of reaction (e.g. dose-related, withdrawal, idiosyncratic, allergic, etc.). ix. Information regarding future screening. x. Physician notification and review of the ADR. xi. Information on the clinical review process, including the clinical review person or team, determination of need for intensive case analysis and other actions. c) VSH does not provide a formalized system of intensive case analysis based on established ADR-related thresholds. d) VSH does not integrate data regarding ADRs in the current system of psychiatric peer review. e) VSH does not provide analysis of individual and group practitioner trends and patterns regarding ADRs and institute meaningful corrective and educational activities for performance improvement.	

d.	drug utilization evaluation ("DUE") in accord with established, up to date medication guidelines	PC	VSH developed guidelines that address clinical and laboratory monitoring of patients receiving mood stabilizers (carbamazepine, lithium, valproic acid, and lamotrigine), second generation antipsychotic medications, tricyclic antidepressants and monoamine oxidase inhibitors). These guidelines do not include indications and contraindications. The guideline regarding the use of second generation antipsychotics does not require prolactin levels routinely for patients receiving risperidone or measures to ensure clinical monitoring of women receiving this medication on along-term basis. These guidelines have yet to be implemented. VSH plans to utilize the newly developed guidelines in a DUE system. The facility has yet to revise the current guideline regarding the use of clozapine to correct the deficiencies in the following areas: a. Indications and contraindications b. Screening requirements c. Adverse effects d. Blood level interpretation e. Interactions with diet and tobacco smoking f. Strategies for use in patients who fail to respond satisfactorily	Finalize and implement individualized psychiatric medication guidelines that include appropriate information regarding indications, contraindications/precautions, adverse effects and screening thresholds/requirements. The guidelines must be derived from current literature and aligned with professional practice guidelines and relevant clinical experience. The guidelines must be continually updated. Develop and implement a DUE system based on the individualized medication guidelines. Ensure that the DUE system prioritizes high-risk and high-volume medication uses. Ensure integration of DUE data in the current peer review system and utilization of data in performance improvement activities.
e.	documentation, reporting, data analyses, and follow up remedial action regarding actual and	PC	VSH has yet to revise its current system of reporting, investigating and	Revise the current data collection tool and system for reporting, investigating

	potential medication variances ("MVR")		analyzing medication variances to address and correct the deficiencies mentioned in the previous report. The following is an outline of these deficiencies: The system is focused on limited categories of variances (e.g. wrong drug, wrong resident, wrong dose and transcription variances). As a result, data provided by VSH regarding the investigation and analysis of variances since January 1, 2006 address only these categories. The failure to include other important categories (e.g. prescription, monitoring, documentation, dispensing, ordering, procurement, storage and found medications) limits the utilization of data in any meaningful performance improvement activity. VSH does not ensure that clinical staff is educated regarding the proper methods of reporting medication variances and of providing information that aid the proper investigation and analysis of the variances. The facility does not provide information or have written guidelines to staff regarding: a. Classification of reporting discipline b. Additional facts involving the variance, including how the variance was discovered, how the variance was perpetuated, relevant individual history, etc.	and analyzing medication variances to address and correct the deficiencies.

			c. Description of the full chain of events involving the variance d. Classification of potential and actual variances e. All medications involved and their classification f. Information regarding critical breakdown points in the common situations that involve more than one category of variance g. Adequate information regarding factors contributing to the variance VSH fails to ensure a system of intensive case analysis of medication variances based on established thresholds. The current system is not integrated in any meaningful fashion in the activities of the P&T Committee, the MRC, the Department of Psychiatry or the Department of Medicine. VSH does not collect and analyze data regarding individual and group practitioner trends and patterns in medication variances. As a result, there is no evidence of performance improvement activity based on this analysis.	
f.	tracking of individual and group practitioner trends	PC	Beginning June 2007, VSH physicians will be provided with a series of reports that reflect prescribing practices. Included in this report portfolio will be individual and cumulative physician use of	Evaluate outcomes of the interventions September 2007.

			contemporaneous neuroleptics; individual and cumulative physician use of PRN medications; individual and cumulative physician number of medications at admission vs. discharge; and individual and cumulative physician medication use by diagnosis.	
g.	feedback to the practitioner and educational/corrective actions in response to identified trends, when indicated	NC	The deficiencies outlined in a through d above preclude meaningful assessment of this requirement at this time.	
h.	use of information derived from ADRs, DUE, MVR, and providing such information to the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees	NC	Same as above.	
3.	By 30 months from the Effective Date hereof, VSH shall ensure that all physicians and clinicians are performing in a manner consistent with generally accepted professional standards of care, to include appropriate medication management, treatment team functioning, and the integration of behavioral and pharmacological treatments.	PC	Initial Psychiatry Assessment without plan: 100%, examples: #s and No rationale for polypharm throughout psychiatry progress notes # (3 antipsychotic meds) # (2-3 antipsychotic meds) aborted cross titration # (2 antipsychotic meds) # (2 antipsychotic meds) Psych med order often absent from chart: almost all, example #	
4.	By 30 months from the Effective Date hereof, VSH shall review and ensure the appropriateness of the medication treatment, consistent with generally accepted professional standards of care.	PC	Standing orders for benzodiazepines without rationale: # #, #, (exception #) Psych Reassessments do not explain polypharmacology: #s	

5.	By 30 months from the Effective Date hereof, VSH shall ensure that individuals are screened and evaluated for substance abuse. For those individuals identified with a substance abuse disorder, VSH shall provide them with appropriate inpatient services consistent with their need for treatment.	PC	A review of nine (9) Substance Abuse Assessments indicates SA assessments do not result in specific treatment recommendations too be implemented at VSH. Inadequate attention to SA: #s (Assessment never done); A full time Substance Abuse position is under recruitment. The Department of Human Resources has provided an approved list of qualified applicants to VSH. Interviews will be schedule after the new Therapeutic Activities Chief begins his position on June 25th. The Therapeutic Activities Chief will supervise the substance abuse clinician.	Inservice Complete hiring process.
B.	Psychological Care By 30 months from the Effective Date hereof, VSH shall provide adequate and appropriate psychological supports and services, consistent with generally accepted professional standards of care, to individuals who require such services.	NC	See below.	
1.	By 30 months from the Effective Date hereof, VSH shall ensure, consistent with generally accepted professional standards of care, adequate capacity to meet the needs of patients in the following areas of psychological services:			
a.	behavioral treatment		There has been no progress in the area of behavioral treatment since the previous report of October 2006.	The lack of progress in this area is such that the VSH needs to appoint a compliance officer to ensure the following:

			The current threshold for provision of behavioral treatment indicates that the facility still fails to provide behavioral treatment for many patients who suffer from a variety of psychiatric symptoms and maladaptive behaviors, including, but are not limited to, aggression that at times requires restrictive interventions, self-care and intellectual deficits and refusal of medications and other treatment and rehabilitation interventions. Many of these individuals are refractory to current pharmacological therapies and their conditions constitute appropriate targets for behavioral interventions. Since October 2006, the facility developed few additional behavioral plans. However, review of these and other behavioral plans and interventions currently provided at the facility showed the same pattern of deficiencies in process and content that were mentioned in the previous report. The process deficiencies include: a) VSH does not have sufficient staffing of trained psychologists to provide needed services. b) VSH does not have a positive behavior support system to ensure integration of this model in the day-to-day operations of the facility. c) Behavioral interventions and plans are not specified in the objectives and interventions sections of the treatment plans. d) There is no mechanism to ensure	• Appropriate indications for referral of patients for the institution of behavioral interventions. • Development and implementation of both formal behavioral plans and behavioral interventions to all individuals in need. • Correction of above process and content deficiencies based on current generally accepted professional standards of care in accordance with the positive behavior support model. • Updates of all positive behavior support plans and interventions as indicated by outcome data. • Documentation of the updates at least quarterly in the present status section of the case formulation in the individual's treatment plan. • Competency-based training of all individuals involved in the formulation and implementation of behavioral treatments.

			that staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and that performance improvement measures are in place for monitoring the implementation of such interventions. The deficiencies in content include: a) There is failure to complete functional analysis of behavior in a manner that meets professional standards. This is an essential prerequisite for effective behavioral interventions. b) Behaviors of concern are generally not well defined, and are not measurable and observable. c) Some maladaptive behaviors are not incorporated in the plans. d) There is little or lack of use of direct observations of behavior. e) Data from functional assessments is not utilized in the assessment of decreases/increases in maladaptive/pro-social behaviors and in the designing of antecedent and consequent treatments. f) The identification of precursor behaviors is inadequate. g) There is failure to obtain data regarding precursors from appropriate sources. h) Reinforcement strategies are generally inadequate and there is no indication of a reinforcement assessment being done.	

			i) The interventions generally do not include identification of replacement skills or means of teaching these skills. When replacement behaviors are identified, they are not functionally equivalent to the function of the maladaptive behavior. j) The interventions generally fail to include strategies to enhance the quality of life of individuals and to develop collateral social behaviors. k) There is failure to train staff on plan implementation as well as lack of monitoring of the appropriateness and consistency of implementation by the team or across situations, individuals or environments. l) There is lack of follow up assessment of the effectiveness of behavioral interventions. m) The behavioral interventions are not integrated with either psychopharmacological therapies or the overall treatment.	
b.	group therapy	NC	No evidence conducted by psychologists as part of objective of treatment plan.	
c.	psychological testing	PC	All appear to be completed by consultant psychologist.	
d.	family therapy;	NC	No consistent application; no clear role for psychologist.	
e.	individual therapy	PC	Appears to be directed by desire of the psychologist rather than patient needs and treatment team decision making.	

2.	By 30 months from the Effective Date hereof, VSH shall provide adequate clinical oversight to therapy groups to ensure that individuals are assigned to groups that are appropriate to their individual needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed consistent with generally accepted professional standards of care.	NC	Rehabilitation Participation Total patients = 51 in am; 50 in pm 10:00-10:30 a.m. scheduled 32 (63%) unscheduled 19 (37%) in attendance 14 (27%) not in attendance 37 (73%) 1:00-1:40 p.m. scheduled could not be determined* unscheduled could not be determined* in attendance ** 8 (16%) not in attendance 42 (84%) * Charge nurse on B2 could not locate schedule and did not know who was scheduled ** One group off the unit, group lasted less than 30 minutes Patient locations Unit Time Location Rehab 11:20 am Bedroom 7 (64%) B2 11:30 am Bedroom 5 (24%) Lunch 11 (52%) B1 11:55 am Bedroom 2 (11%) Smoking brk 8 (44%) Rehab 1:00 pm Bedroom 4 (36%) B2 1:15 pm Bedroom 8 (38%) B1 1:35 pm Bedroom 4 (22%) Dayroom*4 (22%) Hallway 4 (22%)	Creation of a PSR leadership team: one each Rehabilitation, RN, tech. Develop facility-wide off-ward program plan. Develop process such that all patients are in treatment locations during active treatment hours. Develop guidelines for patients who refuse to go (must attend treatment location) or refuse to participate (free not to participate). Prohibit use of treatment groups as contingencies in behavior plans. Create schedule for every patient with not less than 20 hours/week active treatment (treatment directed by treatment plan).

			Bedroom + Dayhall + Hallway 12 (66%) *not a group Group Processes – Group leader makes no attempt to have patient sit facing her or each other – Loud speaker on ward announces "coffee break" and a patient (one of three in the group) gets up and leaves saying, "I'm getting coffee." – Coffee break accoutrements are brought into the middle of a group and coffee is served for the entire unit – Staff did not show up promptly to escort a patient who wanted to go back thus requiring a group leader to leave the room to attend to this single patient – Groups start late, end early – Nurses do not know when groups are scheduled to end – "they only tell me when they start" – There is very little recognition that groups are fundamental tools of rehabilitation and recovery – Groups are used as rewards in behavior programs, failing to recognize they are treatment. This makes as much sense as making the administration of antipsychotic medication contingent on "good" behavior. See plan for ESJ written on 6-21-07.	
3.	By 30 months from the Effective Date hereof, VSH shall provide adequate active psychosocial rehabilitation, consistent with generally accepted	NC	Active Treatment (as documented on weekly schedule). Everything document was consider active ~~treatment so VSH given the benefit of~~	

	professional standards of care, that:		the doubt in all cases in this initial analysis: Pt Hrs/Wk Pt Hrs/Wk 23 26 23 26 12 26 21 31 17 31 20 31 22 31 17 31 17 31 35 31 29 31 32 31 25.5 31 29 31 30 26 26 26 29 26 25 26 28 26 26 26 26 26 26 26 26 26 BUT, these schedules do not actually reflect individual patient's active treatment because: 1. On some units, all patients have the exact same schedule. 2. Groups are shown as one hour in length, but are actually less (probably 45 minutes) since patient need time to travel between groups. 3. Not all groups are dictated specifically in a patient's CITP	
a.	is based on individualized assessment of patients' needs and is directed toward increasing patient ability to engage in more independent life functions	NC		
b.	addresses those needs in a manner building on the individual's strengths, preferences, and interests	NC		
c.	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate	NC		
d.	is provided in a manner consistent with each individual's cognitive strengths and limitations	NC		
e.	is provided in a manner that is clinically appropriate as determined by the treatment team	NC		
f.	routinely takes place as scheduled, for those interventions that are scheduled	NC		

			and any that are not, are not active treatment. 4. Some listed groups have no specified content, but are simply listed as "on unit group." Hence, at this time, VSH has no actual accounting of how much actual active treatment is scheduled for each patient and has even less of an idea of how much active treatment each patient actually receives.	
g.	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life	NC	No evidence this is the case.	
h.	prescribes a role for the staff on the living units	NC	No understanding by staff that "every opportunity is a rehabilitation opportunity."	Requires major culture change.
i.	is documented in the individual's treatment plan	NC	See sec 3 above.	
4.	By 30 months from the Effective Date hereof, VSH shall ensure that:			
a.	behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible	NC	See sec B: Psychological Care.	
b.	programs are consistent for each patient within all settings at VSH	NC	See sec 3 above.	
c.	triggers for considering instituting individualized behavior treatment support plans are specified and utilized, and that these triggers include excessive use of seclusion, restraint, and	NC	See sec B: Psychological Care.	

	emergency involuntary medication			
d.	psychotherapy, whenever prescribed, is goal directed, individualized, and informed by a knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to psychotherapy	NC	See sec B.1.e. above.	
e.	psychosocial, rehabilitative, and behavioral interventions are monitored and revised as appropriate in light of significant developments, and the individual's progress, or the lack thereof	NC	See sec 3 throughout above.	
f.	clinically relevant information remains readily accessible	NC	Information does not exist so it cannot be readily available.	
g.	all staff who have a role in implementing individual behavioral programs have received competency based training on implementing the specific behavioral programs for which they are responsible, and quality assurance measures are in place for monitoring behavioral treatment interventions	NC	Lip service paid to do this. Psychologist orally reports they do this, but no written evidence and no evidence when staff queried.	
C.	Pharmacy Services By 30 months from the Effective Date hereof, VSH shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. By 30 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols that require:			

1.	pharmacists to complete reviews of each individual's medication regimen regularly, on at least a monthly basis, and, as appropriate, make recommendations to treatment teams about possible drug to drug interactions, side effects, medication changes, and needs for laboratory work and testing	SigC	Recently hired personnel.	Evaluate new pharmacy staff.
2.	physicians to consider pharmacists' recommendations, clearly document their responses and actions taken and, for any recommendations not followed, provide an adequate clinical justification	NC	Pharmacy recommendations found; physicians' responses not found	
VIII.	**DOCUMENTATION** By 30 months from the Effective Date hereof, VSH shall ensure that an individual's records accurately reflect the individual's progress as to all treatment identified in the individual's treatment plan, consistent with generally accepted professional standards of care. By 30 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate assessments of the individual's progress relating to treatment plans and treatment goals.	NC	No system. Inadequate monitoring. Incomplete policies and procedures. PSR not effectively documented.	First need to establish services, e.g., PSR, then need to develop system of reliably valid documentation, then need to develop system of communication of information from group leaders to Treatment Teams.
IX.	**RESTRAINTS, SECLUSION AND EMERGENCY INVOLUNTARY**			

	PSYCHOTROPIC MEDICATIONS By 24 months from the Effective Date hereof, VSH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with generally accepted professional standards of care.			
A.	By 18 months from the Effective Date hereof, VSH shall revise, as appropriate, and implement policies and/or protocols regarding the use of seclusion, restraints, and emergency involuntary psychotropic medications consistent with generally accepted professional standards of care. In particular, the policies and/or protocols shall expressly prohibit the use of mechanical restraints in a prone position and shall list the types of restraints that are acceptable for use.	PC	VSH has revised, finalized and implemented its policy and procedure regarding the use of seclusion, restraints and/or involuntary medications. The revised version includes the requirement for treatment team review of the use within three business days for patients who have been in seclusion/restraints more than three times in any four–week period, or when any patient remains in seclusion/restraint for more than four consecutive hours. The current policy and procedure comports with requirements of the settlement agreement, including explicit statement that prohibits the use of mechanical restraints in a prone position. The current policy and procedure requires that all staff implementing restrictive interventions has completed competency-based training regarding the use of these interventions. The facility has provided an outline of the current system of competency-based orientation/training of staff regarding the use of restrictive and less restrictive interventions. The facility provides five-day NAPPI	Ensure that the Mandatory In-Service Policy provides specifics regarding the facility's requirements in the competency-based training of staff (both orientation and annual) in the use of restrictive and less restrictive interventions, including observational and didactic elements of this training. Ensure completeness and accuracy of documentation in the Involuntary Emergency Medication Forms, Certificates of Need (CON) and Post-Incident Considerations Forms. Ensure accuracy of database regarding the use of Involuntary Emergency Medications. Ensure that the psychiatric progress notes and treatment plan reviews address and correct the deficiencies outlined in relevant findings under IX.B. Provide data to assess compliance with the requirement that all staff who monitor patients during the use of restrictive interventions has received competency-based training. Continue current efforts in the Emergency Involuntary Procedures

			training course for all newly hired nursing staff prior to patient contact. Since October 2006, eight additional clinical staff members have received NAPPI certification to serve as trainers (the facility had only two trainers prior to October 2006). In addition, the facility has added a requirement for eight-hour annual refresher training for all nursing staff. This requirement is codified in the facility's mandatory In-Service Policy. VSH has yet to develop systems for tracking compliance with the orientation/training requirements regarding the use of seclusion/restraints.	Reduction Program (EIPRP). Develop and implement requirements for adequate review, analysis and actions by the teams in response to triggers and thresholds of restrictive interventions' use (involuntary emergency psychotropic medications, seclusion and/or restraints). Develop and implement notification and feedback mechanisms to ensure compliance by the teams with recommendation #7 above. Develop and implement tracking and monitoring systems to ensure compliance with above recommendations (as applicable).
B.	By 18 months from the Effective Date hereof, and absent exigent circumstances (i.e., when a patient poses an imminent risk of injury to himself or others), VSH shall ensure that restraints and seclusion:	PC	The above-mentioned policy and procedure adequately addresses the requirements in items B.1 through B.4. To monitor the use of restrictive interventions, VSH uses three types of forms: Involuntary Procedure Order Form and Certificates of Need (CON) (for involuntary medications and seclusion and/or restraints) and Post-Incident Considerations Form (for seclusion/restraints). These forms provide information on the type of emergency intervention, rationale for use, time of administration, criteria for discontinuing the use, presence or absence of medical/psychiatric conditions that should be considered during the use of the intervention. In addition, information is provided regarding the de-escalation measures used, nursing assessment of need for	

			emergency. VSH has revised its system of documenting the use of seclusion and restrain. The revised CON For Emergency Involuntary Procedure provides adequate definitions of seclusion and restraints, parameters for adequate documentation of the use of these interventions and an outline of de-escalation measures that may have been attempted prior to involuntary measures. The information derived from the revised form provides the basis for more accurate data entry into the computerized database that can be used for tracking and entry. The facility is considering changes in the process of the documentation of Post-Incident Considerations to improve the team's review of the incident and discussion with the patient about this review. Review of charts of patients who experienced the use of involuntary medications showed that some of the Involuntary Procedure Order Forms include inaccurate dates for the administration of the medications (e.g. #) or missing information regarding presence or absence of medical or psychiatric conditions that should be considered during the use of the procedure (e.g. #). The database regarding the use of involuntary psychotropic medications sometimes fail to capture episodes of administration (e.g). In addition, the database sometimes includes, by error, the use of seclusion and/or restraints	

			for patients who have not received involuntary medications (e.g. # Review of charts of patients who experienced the use of seclusion and/or restraints showed that the Involuntary Procedure Order Forms, the CONs and Post-Incident Considerations Forms are inconsistently completed. These forms often miss information in the attending physicians' post-incident considerations section regarding the team's review of the procedure and treatment plan changes (e.g. #) as well as information in the Involuntary Procedure Order Form regarding the presence or absence of medical or psychiatric conditions that should be considered during the use of the procedure (e.g. #). Several forms include inaccurate information in the Post-Incident Considerations Forms regarding modifications in the treatment plan being made in response to the procedure. Review of charts indicates that, in general, VSH still fails to ensure the following functions that are essential to appropriate use of restrictive interventions: a. Adequate documentation of the restrictive intervention when more than one intervention is used sequentially (e.g. seclusion followed by restraints). b. Attending physician's review of events that signal the risk of seclusion and/or restraints and proactive modification of	

			scheduled medication strategies to minimize the risk. c. Inconsistent practice regarding the attending physician's modification of regular medication regimen in response to the use of emergency involuntary administration of psychotropic medications. d. Timely and adequate review by the interdisciplinary team of factors that contribute to the incident. e. Update of the interdisciplinary comprehensive case formulation following the use of seclusion and/or restraints. f. Timely and adequate modification by the interdisciplinary team of treatment and rehabilitation interventions to address the impairments that contribute to the use of seclusion and restraints. g. Timely and adequate implementation of behavioral interventions to teach the resident skills that effectively replace maladaptive behaviors resulting in the use of seclusion and restraints. h. Documentation by the interdisciplinary team of the rationale for continuing the treatment plan without modification. i. The database regarding the use of involuntary psychotropic medications fails to capture	

			some episodes of administration (e.g.. j. The database regarding the use of involuntary psychotropic medications sometimes includes, by error, the use of seclusion and/or restraints for patients who have not received involuntary administration of medications ().	
1.	are used in a reliably documented manner and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted	PC	As above.	
2.	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff	PC	As above.	
3.	are not used as part of a behavioral intervention	PC	As above.	
4.	are terminated as soon as the individual is no longer an imminent danger to himself/herself or others, unless otherwise clinically indicated	PC	As above.	
C.	By six months from the Effective Date hereof, VSH shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints. VSH shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency based training on the monitoring of seclusion and restraints.	PC	The above-mentioned policy and procedure includes parameters for adequate and timely implementation. Chart reviews (#) indicated compliance with this requirement in all three cases. However, the facility has yet to provide aggregated training data to ensure compliance with the requirement that all staff who monitors patients has completed competency-based training.	

D.	By 18 months from the Effective Date hereof, VSH shall ensure the accuracy of data regarding the use of restraints, seclusion, or emergency involuntary psychotropic medications.	PC	VSH has developed computerized systems to generate data regarding the use of seclusion and/or restraints and involuntary medications. Review of a random sample of charts verified the accuracy of the facility's database regarding the use of seclusion/restraints (since January 1, 2007). As mentioned above, inaccuracies were found in the database regarding the use of involuntary medications. VSH has maintained efforts to collect and analyze data as part of its Emergency Involuntary Procedures Reduction Program (EIPRP). Based on the facility's data, since January 1, 2006, VSH facility has maintained a downward trend in the frequency of emergency involuntary medications, hours of seclusion per 1000 patient hours and episodes of seclusion. The mean time (hours) per seclusion has remained relatively stable. The restraints' data showed that the episodes, hours per 1000 patient hours and mean time per episode have remained stable since January. The data show that the facility's performance in the use of seclusion and/or restraints is at or below the national average. The facility has conducted data analysis to delineate characteristics of patient populations that require the use of restrictive interventions. VSH has plans to utilize these data to improve the timeliness and other administrative processes involved in the initiation of	

			non-emergency involuntary medications and possible introduction of sensory modulation techniques to effect further reductions on the use of seclusion/restraints.	
E.	By 24 months from the Effective Date hereof, VSH shall revise, as appropriate, and implement policies and/or protocols to require the review within three business days of individuals' treatment plans for any individuals placed in seclusion or restraints more than three times in any four week period, and modification of treatment plans, as appropriate.	NC	Chart reviews demonstrated either failure by the team to review the use and to modify the treatment (#and #) or to provide adequate analysis of the event that provides the basis for modification of treatment (#.	
F.	By 24 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols consistent with generally accepted professional standards of care governing the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:	NC	The current policy and procedure adequately addresses the requirements in F.1 through F.3. Chart reviews (#and #showed progress in ensuring a physician assessment of patients within one hour of the administration of emergency involuntary psychotropic medications. The charts of all patients (#) that met the threshold of three administrations of involuntary medications (within a four week period) were reviewed. In all these cases the facility failed to implement the requirement to modify the individual's treatment plan.	
1.	such medications are used on a time limited, short term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress	NC	As above.	

2.	a physician assess the patient within one hour of the administration of the emergency involuntary psychotropic medication	SubC	As above.	
3.	in a clinically justifiable manner, the individual's core treatment team conducts a review (within three business days) whenever three administrations of emergency involuntary psychotropic medication occur within a four week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as appropriate	NC	As above.	
G.	By 18 months from the Effective Date hereof, VSH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency based training regarding implementation of all such policies and the use of less restrictive interventions.	Unknown	Same as A.	
X.	**PROTECTION FROM HARM** By six months from the Effective Date hereof, VSH shall provide the individuals it serves with a safe and humane environment, ensure that these individuals are protected from harm, and otherwise adhere to a commitment to not tolerate abuse or neglect of individuals, and require that staff investigate and report abuse or neglect of individuals in accordance with this Agreement and with Vermont state statutes governing abuse and neglect as found in 33 V.S.A. § 6901, et. seq.	SigC	VSH has maintained a system of reporting and investigating allegations of abuse/ neglect/ exploitation of residents that complies with Vermont statutes governing abuse and neglect as found in 33 V.S.A. § 6901, et. seq. The system is outlined as follows: a. Reporting by staff to the Executive Director (within 24 hours). b. Immediate notification by the Executive Director of APS of the Division of Licensing and	Implement all above mentioned process improvements. The facility's Infection Control system should develop specific mechanisms to assist staff in securing the scene of a potential investigation regarding issues of exposure to blood-born pathogen. Implement the Quality Management component in the area of abuse/neglect/exploitation. The responsibilities of this department should include, but not be limited to,

	All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. VSH shall not tolerate any mandatory reporter's failure to report abuse or neglect. Furthermore, before permitting a staff person to work directly with any individual, VSH shall investigate the criminal history and other relevant background factors of that staff person, whether full time or part time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at VSH.		protection/ Department of Aging and Disabilities. c. Internal review by the Nursing Administrator or designee to establish circumstances and the facts of the allegation prior to taking personnel actions and to provide further information to APS (as requested by this agency). d. Removal of employees involved in the incident based on a determination by the Executive director of the merit of the allegation. e. Full investigation if APS decides to open the case (depending on results of the internal review. VSH has addressed the findings in the previous monitors' report and made significant progress in correcting the deficiencies that were outlined in the report. The following is a summary of this progress: a) The definitions of abuse and exploitation in the revised Mandatory Reporting Policy include the unnecessary, unlawful or excessive confinement or restraint of a patient. b) The revised Mandatory Reporting Policy includes a clear statement that communicates zero tolerance of abuse, neglect and/or exploitation of residents. c) The revised Mandatory Reporting Policy states that reporting of abuse/neglect/exploitation is based on "any reason to suspect"	the following: a) Systematic review of all event reports and Identification of suspected abuse/neglect/exploitations. b) Systematic review and analysis of all cases of substantiated abuse/neglect/exploitation for "lessons learned." c) Identification of patient and system patterns and trends. d) Initiation and monitoring of corrective actions to reduce future risk. Provide documentation of the factors and circumstances that justify the facility's decision not to remove/reassign staff in all situations of suspected abuse/neglect/exploitation. Provide documentation that all staff members, including discipline heads, that conduct internal reviews of abuse/neglect/exploitation, have received appropriate competency based training in this area. Develop and implement policy and procedure regarding medical emergency code drills. The procedures should address: a) Acceptable range of simulated emergencies (cardiac arrest, airway obstruction, prolonged seizures head injury and hanging) and requirements for staff responsibilities as if it was an actual emergency. b) Implementation of code drills.

			rather than a "reasonable cause to believe that" abuse/neglect/exploitation has occurred. d) The training curriculum regarding abuse/neglect/exploitation has been revised to include risk factors linked to abuse and indicators of abuse. This material should assist staff in the identification of suspected situations. e) The facility has initiated a tracking system of open and closed investigations by APS. f) VSH has developed and implemented a procedure to provide mechanisms to secure of the scene pending an investigation. The mechanisms address 1) the safeguarding of evidence from potential contamination; 2) issues of exposure to blood-born pathogens; 3) securing relevant documentation; and 4) referral of residents involved in allegations of sexual abuse/rape to off-campus medical centers for proper examination. g) The revised Mandatory Reporting Policy delineates the roles of responsible authorities at the facility and includes provisions for quality management review of substantiated incidents for performance improvement purposes. h) The revised Mandatory Reporting Policy includes a statement	c) Code drill monitoring and evaluation systems. d) Performance improvement plans and tracking systems.

			regarding removal/reassignment of staff involved in incidents when the reports are deemed (by the Executive Director) to have merit. The facility has yet to provide documentation of the factors and circumstances that justify the determination of merit in situations where staff were not removed or reassigned. i) VSH provided the curriculum used in the training of staff regarding issues of abuse/neglect and exploitation. The current system is based on orientation training of all employees prior to any patient contact. The training consists of one hour video created by APS, review and discussion of the facility's Mandatory Reporting Policy and signature of an agreement indicating understanding the policy. Ongoing (annual) training consists of a review of an on-line program, named ANGEL. This program includes a post-test in addition to a one hour video developed by APS. j) The revised Mandatory Reporting Policy includes the expectation of disciplinary action regarding delayed reporting by staff of abuse/neglect/ exploitation. k) The revised Mandatory Reporting Policy states that persons reporting abuse/neglect/exploitation are immune from liability. The policy codifies the expectation	

			that these persons are not subject to retaliation for making good faith reports. VSH has an adequate system that tracks the reporting of incidents to APS. The tracking system includes the date and type of incident, the names of individuals involved and witnesses, location and brief description of the incident and actions taken and outcome. Since January 207, the facility has gathered additional information on how the report was initiated and provided to APS. The database indicates that 22 incidents were reported to APS since January 1, 2007 and that only four incidents have been investigated by APS to date (one is pending). The investigations included two incidents involving events that antedated hospitalization. Of all incidents of reporting, 17 were initiated by the patient and five by staff (three involved events prior to hospitalization). Of the two investigations involving events during hospitalization, one was substantiated and the outcome of the second investigation is pending. The staff involved in the substantiated case was terminated and the staff involved in the pending case has been placed on administrative leave. In both incidents, reporting was initiated by staff. The facility has maintained an adequate system to investigate the criminal history and other relevant	

			background factors of potential employees to ensure that the employee would not pose a risk of harm to the residents. The system includes Vermont and nationwide and adult abuse record checks based on inquiries made to the Vermont Criminal Investigation Center and APS. In addition, since March 1, 2007, the facility has required that volunteers, interns and consultants receive orientation to (and signify their awareness of) the facility's procedures and expectations in the area of abuse/neglect/exploitation. VSH has maintained an adequate system for processing and tracking grievances of residents. VSH has continued its practice to ensure that posters regarding abuse/neglect/exploitation and grievance reporting systems are placed in public view of staff and patients on the units and that the information in these posters is clear and understandable. VSH has made progress in the development of systems to ensure patients' protection from potential harm in the area of medical emergency response. The following is an outline of the facility's current status: a) VSH developed and implemented an adequate medical emergency response procedure that outlines a system for the immediate response, assessment and initial care of residents with medical	

			emergencies pending transfer to an acute care facility. b) The Safety and Risk Management Committee initiated an adequate system of daily checks of the Emergency Carts for the presence and integrity of emergency kits (medical emergency supplies and small equipment and emergency medications) to ensure that they are available and functional. Facility's audit data indicate 100% compliance during the past four months. c) VSH purchased three new AEDs to assure availability of one AED on each patient care unit. d) VSH has included staff training on AED as part of the mandatory annual training on BCLS. The training is based on the manufacturer's instructions. e) VSH has yet to develop and implement a procedure of medical emergency response drills at designated intervals to evaluate staff competence and performance of systems and to provide corrective actions for identified problems.	
XI.	**INCIDENT MANAGEMENT** By 12 months from the Effective Date hereof, VSH shall develop and implement, across all settings, an integrated incident management system that is consistent with generally accepted professional standards of care.			

A.	By 12 months from the Effective Date hereof, VSH shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies and/or protocols, procedures, and practices shall require:	SigC	VSH does not have a Mortality/Morbidity Review Committee. There have been no 2007 deaths to date. Since October 2006, VSH has made progress in incident management as follows: a) VSH has established a Quality Management (QM) Department, with a Chief Quality Officer, a Clinical Director (Quality Manager), a Quality Improvement Analyst and an Administrative Assistant. b) VSH has established an IT Department, with a Director and a System's Analyst working in collaboration with the QM Department. c) The facility's IT function has implemented application software and databases to enable data analysis and reporting. The following are examples of new electronic capabilities: i. Databases regarding staff members involved in more than one event, patient-to-patient altercations resulting in injury, patients involved in more than one allegation of abuse/neglect/exploitation and repeat aggressors and victims in patient-to-patient altercations ii. Tracking of delayed reporting by staff of abuse/neglect/exploitation iii. Tracking of corrective actions	Implement newly developed IT function to ensure accuracy and completeness of databases regarding patient events. The databases should include, but not be limited to, patient-to-patient altercations with and without injuries, perpetrators and victims of altercations, allegations of abuse, neglect and/or exploitation and the status of investigations, staff injuries, staff involvement in events, medication use, including ADRs and medication variances, use of restrictive interventions and corrective actions regarding identified trends. Continue current practice as outlined in findings #1-6 and 8. Same as sections X (Protection from Harm) and Section VII.A. (Reporting of ADRs and MVR). Develop and implement procedures/mechanisms to address and correct deficiencies outlined under finding #10.

			in abuse/neglect/exploitation iv. Tracking of medication uses, including polypharmacy v. Medication Administration Record (MAR) vi. PRN expiration report vii. Medication variances reporting viii. Anonymity of staff reporting medication variances ix. Tracking of therapeutic group activity x. Weekly report to the interdisciplinary teams of restrictive interventions' use xi. Tracking of therapeutic group activity xii. Shared data across applications The facility has maintained an adequate database regarding incidents that result in injuries to its patients. The database includes patient names and record numbers, unit of residence, date of injury, brief description of the nature of injury and its cause, severity rating of the injury and brief statement regarding follow-up actions. Review of the database () indicates that two incidents have resulted in an injury of moderate or serious nature (#). In one case, the injury had been sustained prior to admission (#). Review of the chart of (#) showed that the patient fainted in the bathroom and sustained bruises to the head and pain in the back of the head (). The chart includes evidence of timely and appropriate emergency medical intervention and	

			follow-up. As mentioned earlier, VSH has an adequate system for reporting allegations of abuse/neglect/exploitation. The system is codified in the Mandatory Reporting Policy. Please see findings under Protection from Harm (Section X). VSH has maintained its system for reporting of Sentinel Events and Incident Events. The Patient Event Reporting Policy includes adequate definitions of sentinel and incident events and outlines the reporting procedures. The facility has not had an event that met the definition of a sentinel event since September 2003. The facility has maintained an adequate database regarding incidents that result in injuries to its patients. The database includes patient names and record numbers, unit of residence, date of injury, brief description of the nature of injury and its cause, severity rating of the injury and brief statement regarding follow-up actions. Review of the database) indicates that two incidents have resulted in an injury of moderate or serious nature (#). In one case, the injury had been sustained prior to admission (#. Review of the chart of (#) showed that the patient fainted in the bathroom and sustained bruises to the head and pain in the back of the head (). In this case, the chart includes evidence of timely and appropriate emergency medical	

			intervention and follow-up. VSH has an adequate system for reporting employee injuries as described in the Employee First Report of injury Protocol. The facility plans to utilize its IT resources to refine its system for reporting employee events, with an anticipated completion date in September 2006. The facility has identified trends in employee injuries and contributing factors, including insufficient staffing levels and active treatment hours for patients during the evening shift. The facility has implemented corrective actions to augment staffing levels. In addition, the facility is currently reviewing opportunities to increase active treatment hours by various categories of workers. VSH has a system (Variance Event Reporting Protocol) for reporting incidents that are not addressed in the above-mentioned reporting procedures/protocols. Examples of these events include reporting of adverse drug reactions (ADR) and medication variances (MVR). Please see relevant findings under Specific Treatment Services-Psychiatric Care (Section VII.A). VSH has maintained an adequate procedure to report patient criminal activity to law enforcement. As mentioned earlier, the facility has recently developed and implemented VSH has maintained a process for risk assessment (LOCUS rating scale) of	

			patients upon admission, during hospitalization and at the time of discharge. In addition to the findings outlined under sections X (Protection from Harm) and VII.A (ADR reporting and MVR), the current system of incident and risk management demonstrates the following deficiencies: a) The facility does not ensure that the interdisciplinary teams continually assess and document the benefits and risks of different treatment and rehabilitation services in order to optimize the benefits and minimize the risks. A related deficiency concerns the team's limited or lack of review of factors that contribute to the use of seclusion, restraints and/or emergency involuntary medications. b) The current system of assessment of risk factors upon admission does not include adequate analysis of how recent the risk is relevance of the risk to dangerousness and mitigating factors. c) The current system of data collection (data collection tools and centralized database) is limited to reports of patient and employee injuries. The system has yet to utilize the newly developed IT resources to capture and provide information on other categories of high risk situations	

			d) At this time, VSH does not have an organized system of triggers, thresholds and high risk lists to identify situations of immediate and long-term nature requiring clinical and systemic interventions. e) VSH dose not have a system that guides staff regarding a hierarchy of interventions commensurate with the level of risk. f) VSH has yet to implement mechanisms for notification of the clinical providers/teams regarding the need to implement specific interventions and of feedback by the providers/teams regarding the status of implementation. g) VSH has yet to formalize mechanisms to monitor the timely ad appropriate implementation of interventions by providers/teams. h) VSH has to conduct further analysis of long-term trends and patterns of high-risk situations and to initiate and monitor the outcomes of corrective actions based on performance improvement methodologies. i) VSH has yet to formalize and implement its Quality management function as it pertains to: 1) identification of patterns/trends in a timely and appropriate manner; 2) initiation of performance improvement projects; 3) monitoring the	

			implementation and outcomes of corrective interventions; and 4) reporting in a systematic fashion to the facility's administrative leadership.	
1.	identification of the categories and definitions of incidents to be reported and investigated; immediate reporting by staff to supervisory personnel and VSH's executive director (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all settings	SigC	Same as above.	
2.	mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with individuals pending the investigation's outcome	SigC	Same as above.	
3.	adequate training for all staff on recognizing and reporting incidents	SigC	Same as above.	
4.	notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents to VSH and State officials	SigC	Same as above.	
5.	posting in each patient care unit a brief and easily understood statement of how to report incidents	SigC	Same as above.	
6.	procedures for referring incidents, as appropriate,	SigC	Same as above.	

	to law enforcement			
7.	mechanisms to ensure that any staff person, individual, family member, or visitor who, in good faith, reports an allegation of abuse or neglect is not subject to retaliatory action by VSH and/or the State, including but not limited to reprimands, discipline, harassment, threats, or censure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner	SigC	Same as Section X (Protection from harm).	
B.	By 12 months from the Effective Date hereof, VSH shall review, revise, as appropriate, and implement policies and/or protocols to ensure the timely and thorough reporting of incidents to the Division of Licensing and Protection pursuant to 33 V.S.A. § 6901, et seq.	SigC	Same as Section X (Protection from harm).	
C.	By 12 months from the Effective Date hereof, whenever remedial or programmatic action is necessary to correct a reported incident or prevent re-occurrence, VSH shall implement such action promptly and thoroughly and track and document such actions and the corresponding outcomes.	SigC	Same as A above.	
D.	By 12 months from the Effective Date hereof, records of the results of every investigation of abuse, neglect, and serious injury shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff	SigC	The facility maintains records of all internal reviews of abuse/neglect/exploitation allegations. The database indicates whether an investigation by APS was initiated or not, but no more information is available regarding these investigations.	

	member or individual.			
E.	By 12 months from the Effective Date hereof, VSH shall have a system to allow the tracking and trending of incidents and results of actions taken. Trends shall be tracked by at least the following categories:	SigC	Same as A above and Section X (Protection from Harm).	
1.	type of incident			
2.	staff involved and staff present			
3.	individuals involved and witnesses identified			
4.	location of incident			
5.	date and time of incident			
6.	cause(s) of incident			
7.	actions taken			
XII.	**QUALITY IMPROVEMENT** By 30 months from the Effective Date hereof, VSH shall develop, revise, as appropriate, and implement quality improvement mechanisms that provide for effective monitoring, reporting, and corrective action, where indicated, to include substantial compliance with this Agreement. The quality improvement methodologies shall be otherwise consistent with generally accepted professional quality improvement standards and shall:	SigC	Same as Section XI (Incident Management).	Same as Section XI (Incident Management).

A.	track data, with sufficient particularity for actionable indicators and targets identified in the Agreement, to identify trends and outcomes being achieved			
B.	analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality improvement process. Such plans shall identify:			
1.	the action steps recommended to remedy and/or prevent the reoccurrence of problems			
2.	the anticipated outcome of each step			
3.	the person(s) responsible and the time frame anticipated for each action step			
C.	provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:			
1.	disseminating corrective action plans to all persons responsible for their implementation			
2.	monitoring and documenting the outcomes achieved			
3.	modifying corrective action plans as necessary			
D.	utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve VSH's quality/performance goals,			

	including identified outcomes.			
XIII.	**ENVIRONMENTAL CONDITIONS** By 12 months of the Effective Date hereof, VSH shall develop and implement a system to regularly review all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. The system shall attempt to identify potential suicide hazards and expediently correct them. Furthermore, VSH shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.	PC	Funding approved June 2007 to complete all safety renovations for Brooks.	Complete work.

CONCLUSION

VSH has made significant progress between our first and second compliance visits. The staff of VSH at all levels should be pleased with the outcomes their efforts have yielded to date. As our report indicates, there remains much to be done, especially in areas that have not advanced as much (or at all) as other areas of VSH.

We look forward to visiting in October for our third compliance visit; we shall particularly focus on areas currently judged to be out of compliance.

Respectfully submitted,

Jeffrey L. Geller, M.D., M.P.H. Mohamed El-Sabaawi, M.D.

JLG/MES:vab